Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for dates of service 2-27-01 through 3-1-01.

   b. The request was received on 2-25-02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. UB 92
   c. EOBs
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. UB 92
   c. EOBs
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 6-4-02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 6-4-02. The response from the insurance carrier was received in the Division on 6-17-02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 2-25-02:

   "Based upon review by the insurance carrier, …., and its audit department, alleges that the aforementioned claim has been denied for no authorization….Pursuant to the TWCC

fee guidelines, the claim pertaining to dates of service: 02/27/01 – 03/01/2001, is to be paid as follows:

Paid @ 65% of total billed charges ($9,148.94) =		$ 5,946.91
Complex medical equipment-routine	=	$ 229.25
Total allowable:		$6,176.06"

2. Respondent: Letter dated 6-17-02:
"Provider seeks reimbursement for a three day hospital stay provided to ('Claimant') from 2/27/01 through 3/1/01…Contrary to the Provider's assertions, the services and treatments at issue were not preauthorized. Further, the services at issue were not provided due to a medical emergency; therefore, the Provider is not entitled to reimbursement."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 2-27-01 and extending through 3-1-01.

2. The provider billed $9,148.94 for date of service 2-27-01 through 3-1-01.

3. Table of Disputed Services reflects the carrier paid $-0-.

4. The EOB dated 11-20-01 reflects a denial of "F – Reduction According to Fee Guideline" with a recommended allowance of $6,176.06.

5. The amount in dispute is $6,176.06.

V. RATIONALE

Medical Review Division's rationale:

The provider has billed for services rendered for dates of service 2-27-01 through 3-1-01. The EOBs reviewed indicated the charges had been reduced pursuant to, "F – Reduction According to Fee Guideline". The EOB dated 11-20-01 also reflected a recommended allowance of $6,176.06. Both parties have raised an additional denial of preauthorization in their position statements. However, there were no EOBs noted to support this denial.

It is Medical Review's determination that a recommendation of payment has been made from the Carrier to the provider, and the only denial code listed on the EOBs reviewed was "F".

The carrier has not expounded on the "F" denial by not listing the specific areas of the Fee Guideline that the Provider has failed to follow. TWCC Rule 133.304 (c) states, "At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s). A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for the reduction or denial of payment does not

satisfy the requirements of this section." As the Carrier has not provided sufficient explanation of their denial of "F", as required by Rule 133.304 (c).

Therefore, reimbursement is recommended pursuant to TWCC Rule 134.401 (c) in the amount of **$3,354.00.** The Medical Review Division cannot recommend reimbursement greater that the rules allow. The amount of reimbursement that can be recommended is based on, **"**Standard Per Diem Amount. The workers' compensation standard per diem amount to the used in calculating the reimbursement for acute care inpatient services are as follows:…Surgical $1,118.00…". Therefore, reimbursement is recommended in the amount of $3,354.00. ($1,118.00 x 3 day inpatient stay = $3,354.00).

The above Findings and Decision are hereby issued this 1st day of October 2002.

Lesa Lenart
Medical Dispute Resolution Officer
Medical Review Division

LL/ll

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit **$3,354.00** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 1st day of October 2002.

Carolyn Ollar
Medical Dispute Resolution Supervisor
Medical Review Division